

**Teamsters Joint Council No. 83 of VA Health & Welfare Fund**

**Plan 11**

**Effective July 1, 2009**

BENEFIT	PLAN 11	SUBJECT TO
<b>LIFE INSURANCE</b>		
Employee	\$27,000	
Accidental Death & Dismemberment (Employee Only)	\$27,000	
Permanent and Total Disability (Employee Only)	\$13,500	
Spouse	\$3,000	
Child	\$1,500	
<b>SHORT TERM DISABILITY</b>		
Employee Only	\$250/week	
Maximum Weeks	26	
Free Coverage	22 weeks	
<b>HOSPITALIZATION</b> ▪ 120 days per person per year (in-patient)		
<b><u>In-Network (In-patient or Out-patient)</u></b> In-network hospital charges for room/board and miscellaneous (necessary services & supplies)	90% of BCBS allowable charge	AM, CI, DED, OOP, LM
<b><u>Out-of-Network - Non-emergency room based admission</u></b> Out-of-network hospital charges for room/board and miscellaneous (necessary services & supplies)	70% of BCBS allowable charge	
<b><u>Out-of-Network - Admission after visit to emergency room</u></b> Out-of-network hospital charges for room/board and miscellaneous (necessary services & supplies)	90% of BCBS allowable charge	
<b>SURGERY</b>		
In-Network	90% of BCBS allowable charge	CI, DED, OOP, LM
In-Network Colonoscopy (Out-patient only)	100% of BCBS allowable charge	LM
Out-of-network	70% of BCBS allowable charge	CI, DED, OOP, LM
<b>PRESCRIPTION DRUGS</b> ▪ If you have a condition treatable by the Horse Power Healthy Rewards Program, all generic medicines are free while participating in the Reward Program.		
Prior Authorization Required for:		CP, LM, CI
<ul style="list-style-type: none"> <li>• Anti-obesity drugs (Xenical, Meridia), Second generation antihistamines, (e.g. Clarinex, Allegra, Zyrtec, Clarinex D, Allegra D), Proton pump inhibitors (e.g., Prevacid, Protonox, Nexium, Aciphex), Actiq, Gleevec, Iressa, Revlimid, Tarceva, Thalomid, Tracleer</li> <li>• All injectable medications with the exception of Byetta, Cyanocobalamin, Delatestryl, Delestrogen, DepoTestosterone, Dexamethasone, Furosemide, Haloperidol, Heparin, Insulin, Lidocaine, Lorazepam, Methotrexate, Nubain, Progesterone, Promethazine, Sodium Bicarbonate, Symlin</li> </ul>		
Retail - 30 day supply Viagra, Cialis, or equivalent drug limited to 8 units per month	20% co-pay - \$5 minimum	
Mail Order Maintenance Drugs -100 day supply Mail Order Specialty (Injectable) drugs - 30 day supply	\$20 Generic \$45 Brand	
<b>DOCTOR VISIT</b> ▪ One co-pay applies per person per date of service. (Higher co-pay will apply when specialist is seen.)		
<b><u>In-network</u></b>		CP, LM
<ul style="list-style-type: none"> <li>• \$15 co-pay for charges incurred at family or general practitioner, pediatrician, internal medical physician or urgent care center (i.e., Patient First)</li> <li>• \$25 co-pay for charges incurred at specialist</li> <li>• Co-pay covers all charges incurred at doctor's office. This could include x-ray, lab, drugs (i.e., chemotherapy, allergy serum, administration of injections, etc.)</li> <li>• Increased co-pays apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate</li> </ul>		
<b><u>Out-of-network</u></b>		
70% of BlueCross BlueShield allowable charge		

AM -- Annual Maximum	AVL -- Annual Visit Limit
CI -- Co-Insurance	CP -- Co-Payment
DED -- Deductible	LM -- Lifetime Maximum
LVL -- Lifetime Visit Limit	OOP -- Out of Pocket Limit

BENEFIT	PLAN 11	SUBJECT TO
<b>CHIROPRACTIC/MUSCULOSKELETAL</b>		
Benefit	\$25 co-pay	CP, AVL, LM
Annual Max/Year	10 visits per year	
<b>HEARING AIDS</b>		
Benefit	80% of BCBS allowable charge (maximum allowable charge - \$700)	DED, AM, LM, CI
Maximum Benefit	One hearing aid per ear every five years	
<b>X-RAY</b>		
In-Network (In or Out-Patient)	90% of BCBS allowable charge	CI, DED, LM, OOP, AM
<b>Exceptions (only apply to in-network/out-patient services):</b> EKG Bone Density (Medical guidelines only) Mammography (Routine)	100% of BCBS allowable charge	LM
Out-of-Network (In or Out-Patient)	70% of BCBS allowable charge	CI, DED, LM, OOP, AM
<b>LAB</b>		
In-Network (Out-Patient)	100% of BCBS allowable charge	LM
In-Network (In-Patient)	90% of BCBS allowable charge	CI, DED, LM, OOP, AM
Out-of-Network (Out-Patient)	70% of BCBS allowable charge	CI, DED, LM, OOP, AM
Out-of-Network (In-patient)	70% of BCBS allowable charge	CI, DED, LM, OOP, AM
<b>ANNUAL DEDUCTIBLE (NOT INCLUDED IN OUT-OF-POCKET LIMIT)</b>		
Individual - \$250 Family - \$750	Deductible applies to all charges incurred except dental claims, amounts above BCBS allowable charges, lab and x-ray procedures paid at 100%, co-pays for doctors and emergency room visits and prescription drug claims.	
<b>LIFETIME MAXIMUM - PER PERSON -- \$2 MILLION</b>		
<b>ANNUAL OUT-OF-POCKET LIMIT</b>		
<u>In-network</u> \$2,000 per person \$6,000 per family	<u>Out-of-network</u> \$6,000 per person \$18,000 per family	
<b>EMERGENCY ROOM AND ALL RELATED CHARGES</b>		
<ul style="list-style-type: none"> <li>\$100 co-pay applies whether in-network or out-of-network</li> <li>Increased co-payments apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate.</li> </ul>		
<b>OTHER ALLOWABLE MAJOR MEDICAL EXPENSES</b> Physical Therapy, Speech Therapy, and Occupational Therapy - Maximum 20 visits each per person, per year		
Other allowable, in-network expenses	80% of BCBS allowable charge (i.e., administration of allergy injections)	DED, LM, CI, OOP, AVL, AM
Other allowable, out-of-network expenses	70% of BCBS allowable charge	

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BENEFIT	PLAN 11	SUBJECT TO																											
<b>TRANSPLANT COVERAGE - HOSPITAL &amp; SURGICAL</b>																													
In-network	90% of BCBS allowable charge	CI, OOP, LM, DED																											
Out-of-network	70% of BCBS allowable charge																												
<b>TRANSPLANT COVERAGE FOLLOW-UP CARE</b>																													
	<table border="1"> <thead> <tr> <th>Organ</th> <th>Annual Follow-up</th> <th>Lifetime Follow-up</th> </tr> </thead> <tbody> <tr> <td>Heart</td> <td>\$15,000</td> <td>\$75,000</td> </tr> <tr> <td>Heart/lung</td> <td>\$20,000</td> <td>\$100,000</td> </tr> <tr> <td>Lung</td> <td>\$20,000</td> <td>\$100,000</td> </tr> <tr> <td>Liver</td> <td>\$15,000</td> <td>\$75,000</td> </tr> <tr> <td>Pancreas</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>Kidney</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>Bone marrow</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>Cornea</td> <td>None</td> <td>None</td> </tr> </tbody> </table>	Organ	Annual Follow-up	Lifetime Follow-up	Heart	\$15,000	\$75,000	Heart/lung	\$20,000	\$100,000	Lung	\$20,000	\$100,000	Liver	\$15,000	\$75,000	Pancreas	\$10,000	\$50,000	Kidney	\$10,000	\$50,000	Bone marrow	\$10,000	\$50,000	Cornea	None	None	AM, LM DED, CI
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Cornea	None	None																											
<b>DENTAL (INCLUDING TMJ)</b>																													
100% of dental schedule		AM, CI																											
Dental annual max	\$3,000/family																												
Orthodontic/eligible dependent	\$2,000 Lifetime Maximum (24 month waiting period)	LM, CI																											
<b>VISION (OUT-OF-NETWORK)</b> Only one exam is payable during a calendar year. Two lenses and one set of frames or two contact lenses (includes a one-time purchase of disposable contact lenses, payable as shown below) are payable during a calendar year. No combination of frames and contact lenses will be covered.																													
Exam	\$35.00	CI, AM																											
Frames	\$40.00																												
Single Lenses, Pair	\$40.00																												
Bifocal Lenses, Pair	\$55.00																												
Trifocal Lenses, Pair	\$70.00																												
Lenticular Lenses, Pair	\$80.00																												
Contacts	\$80.00	LM, AM																											
EyeMed Vision Care Network Plan Option	High																												

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